Washington State Department of Labor & Industries
Workers' Compensation Services

Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims

Chapter 16: Medication Administration

Effective July 1, 2011 (Republished February 1, 2012)

Link: Look for possible **updates and corrections** to these payment policies at www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2011/default.asp#3

Table of contents

Definitions

- **Bundled:** A bundled procedure code isn't payable separately because its value is accounted for and included in the payment for other services. Bundled codes are identified in the fee schedules.

  Pharmacy and DME providers can bill HCPCS codes listed as bundled in the fee schedules. This is because, for these provider types, there isn't an office visit or a procedure into which supplies can be bundled.

  Link: For the legal definition of "bundled," see WAC 296-20-01002.

- **By report (BR):** A code listed in the fee schedule as "BR" doesn't have an established fee because the service is too unusual, variable, or new. When billing for the code, the provider must provide a report that defines or describes the services or procedures. The insurer will determine an appropriate fee based on the report.

  Link: For more information, see WAC 296-20-01002.

- **CPT® and HCPCS code modifiers mentioned in this chapter:**

  –25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure

  Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

  –LT Left side

  Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

  –RT Right side

  Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

- **Dry needling:** A technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. Dry needling is considered a variant of trigger point injections with medications.

Payment policy: Hyaluronic acid for osteoarthritis of the knee

Prior authorization

Hyaluronic acid injections are **only allowed** for osteoarthritis of the knee. Other uses are considered experimental, and therefore will not be paid.

Link: For more information about treatments that aren't authorized, see WAC 296-20-03002(6).

For authorization, the correct side of body HCPCS billing code modifier (**–RT** or **–LT**) is required. If bilateral procedures are required, both modifiers must be authorized.

Requirements for billing

CPT® code **20610** must be billed for hyaluronic acid injections along with and the appropriate HCPCS code:

If the **injection** is…	Then the appropriate **HCPCS billing code** is:	Which has a **maximum fee** of:
Hyalgan or Supartz	**J7321**	**$131.20**
Euflexxa	**J7323**	**$185.45**
Orthovisc	**J7324**	**$243.00**
Synvisc or Synvisc-1	**J7325**	**$15.84** per mg

The correct side of body HCPCS code billing modifier (**–RT** or **–LT**) is required for billing. If bilateral procedures are authorized, both modifiers must be billed as a separate line item.

Additional information: Hyaluronic acid injections

Link: For more information about hyaluronic acid injections, see www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/hyaluronicacid.asp.

Payment policy: Immunizations

Prior authorization

Immunization materials are payable when authorized.

Services that can be billed

CPT® codes **90471** and **90472 are payable**, in addition to the immunization materials code(s).

For each additional immunization given , add-on CPT® code **90472** may be billed.

Payment limits

E/M codes aren't payable in addition to the immunization administration service, **unless** the E/M service is:

- Performed for a separately identifiable purpose, *and*
- Billed with a **–25 modifier**.

Additional information: Blood-borne pathogens and infectious diseases

Link: For more information on blood-borne pathogens, see www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/PEP/default.asp#1.

For more information about work-related exposure to an infectious disease, see WAC 296-20-03005.

Payment policy: Immunotherapy

Services that aren't covered

Complete service codes aren’t paid.

Requirements for billing

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. The provider bills:

- One of the injection codes, *and*
- One of the antigen/antigen preparation codes.

Payment policy: Infusion therapy services and supplies for RBRVS providers

Prior authorization

Regardless of who performs the service, prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic, or home.

Note: Exception: Outpatient services are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. (See "Services that can be billed," below.)

With prior authorization, the insurer may cover:

- Implantable infusion pumps and supplies,
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal, *and*
- Antispasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, Baclofen).

Services that can be billed

Urgent and emergent outpatient services

Outpatient services are allowed when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. The following CPT® codes are payable to physicians, ARNPs, and PAs:

- **96360**,
- **96361**, *and*
- **96365-96368**.

Supplies

Implantable infusion pumps and supplies that may be covered with prior authorization include these HCPCS codes:

- **A4220**,
- **E0782 – E0783**, *and*
- **E0785 – E0786**.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of medications is covered.

Services that aren't covered

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material aren't covered.

Link: For more information, see WAC 296-20-03002.

Requirements for billing

Equipment and supplies

Durable medical equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the payment policy for "Home infusion services" in the Home Health Services chapter for more information.

Link: For information on home infusion therapy in general, see the "Home infusion services" section of the Home Health Services chapter.

Note: Billing instructions for non-pharmacy providers are detailed in the "Payment policy" for "Injectable medications" (the next section of this chapter).

Drugs

Drugs supplied by a pharmacy must be billed on pharmacy forms with national drug codes (NDCs or UPCs if no NDC is available).

Payment limits

E/M office visits

Providers will be paid for E/M office visits in conjunction with infusion therapy only if the services provided meet the code definitions.

Opiates

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) aren't covered **unless** they are:

- Part of providing anesthesia, *or*
- Short term post operative pain management (up to 48 hours post discharge), *or*
- Medically necessary in emergency situations.

Link: For more information, see WAC 296-20-03014.

Equipment and supplies

Infusion therapy supplies and related DME, such as infusion pumps, aren't separately payable for RBRVS providers. Payment for these items is **bundled** into the fee for the professional service).

Note: See definition of **bundled** in "Definitions" at the beginning of this chapter.

Diagnostic injections

Intravenous or intra-arterial therapeutic or diagnostic injection codes, CPT® codes **96373 and 96374,** won't be paid separately in conjunction with the IV infusion codes.

Payment policy: Injectable medications

Requirements for billing

Providers must use the HCPCS **J** codes for injectable drugs that are administered during an E/M office visit or other procedure.

Note: The HCPCS **J** codes aren't intended for self administered medications.

When billing for a non-specific injectable drug, the following must be noted on the bill and documented in the medical record:

- Name,
- NDC,
- Strength,
- Dosage, *and*
- Quantity of drug administered or dispensed.

Although L&I's maximum fees for injectable medications are based on a percentage of AWP and the drug strengths listed in the HCPCS manual, providers must bill their acquisition cost for the drugs. To get the total billable units, divide the:

- Total strength of the injected drug *by*
- The strength listed in the manual.

For **example**:

- You administer a 100 mg injection.
- The HCPCS manual lists the strength as 10 mg.
- Your billable units are 100 mg (administered) divided by 10 mg (strength) = 10 units.

Payment limits

Payment is made according to the published fee schedule amount, or the acquisition cost for the covered drug(s), whichever is less.

Payment policy: Non-injectable medications

Services that can be billed

Providers may use distinct HCPCS **J** codes that describe specific non-injectable medication administered during office procedures.

- Separate payment will be made for medications with distinct J codes.

Note: The HCPCS **J** codes aren't intended for self administered medications.

Services that aren't covered

No payment will be made for pharmaceutical samples.

Requirements for billing

The name, NDC, strength, dosage and quantity of the drug administered must be documented in the medical record and noted on the bill.

Providers must bill their acquisition cost for these drugs.

Link: For more information, see the payment policy for "Acquisition cost" in the Supplies, Materials, and Bundled Services chapter.

Payment limits

Miscellaneous oral or non-injectable medications administered or dispensed during office procedures are considered **bundled** in the office visit. No separate payment will be made for these medications:

- **A9150** (Nonprescription drug), *or*
- **J3535** (Metered dose inhaler drug), *or*
- **J7599** (Immunosuppressive drug, NOS), *or*
- **J7699** (Non-inhalation drug for DME), *or*
- **J8498** (Antiemetic drug, rectal/suppository, NOS), *or*

- **J8499** (Oral prescript drug non-chemo), *or*
- **J8597** (Antiemetic drug, oral, NOS), *or*
- **J8999** (Oral prescription drug chemo).

Note: See the definition of **bundled** in "Definitions" at the beginning of this chapter.

Payment policy: Therapeutic or diagnostic injections

Services that can be billed

E/M office visit services provided on the same day as an injection may be payable if the services are separately identifiable.

Professional services associated with therapeutic or diagnostic injections (CPT® code **96372**) are payable along with the appropriate HCPCS **J** code for the drug.

Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes **96373** and **96374**) may be billed separately and are payable if they aren't provided in conjunction with IV infusion therapy services (CPT® codes **96360, 96361, 96365-96368**).

Services that aren't covered

CPT® code **99211** won't be paid separately.

Note: If billed with the injection code, providers will be paid only the E/M service and the appropriate HCPCS **J** code for the drug.

The insurer doesn't cover acupuncture services.

Links: For more information about the coverage decision for acupuncture services, see WAC 296-20-03002 and online at www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Acupuncture.asp.

Requirements for billing

Separate E/M services (CPT® codes **99212-99215**) must be billed using a **–25 modifier**.

Dry needling of trigger points must be billed using CPT® codes **20552** and **20553**.

Note: See the definition of **dry needling** in "Definitions" at the beginning of this chapter.

Payment limits

Injections of narcotics or analgesics aren't permitted or paid in the outpatient setting **except**:

- On an emergency basis, *or*
- For pain management related to outpatient surgical procedures and dressing and cast changes, *or*
- For severe soft tissue injuries, burns or fractures.

Link: For more information, see WAC 296-20-03014.

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules (Washington state laws) for drug limitations (such as opiates)	Washington Administrative Code (WAC) 296-20-03014: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-03014
Administrative rules for treatment authorization	WAC 296-20-03002: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-03002
Administrative rules for work-related exposure to an infectious disease	WAC 296-20-03005: http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-03005
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp
Billing instructions and forms	Chapter 1: Introduction
Bloodborne pathogens	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/PEP/default.asp#1
Fee schedules for all healthcare professional services (including medication administration)	L&I's website: http://feeschedules.Lni.wa.gov
Hyaluronic acid injections	L&I's website: www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/hyaluronicacid.asp
Medical coverage decision for **acupuncture**	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Acupuncture.asp
Payment policies for **acquisition cost policy**	Chapter 28: Supplies, Materials, and Bundled Services
Payment policies for **home infusion therapy**	Chapter 11: Home Health Services

- **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**.